DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED

HEALTH CARE FINANCING ADMINISTRATION OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 02-16	2. STATE Louisiana
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE September 7, 2002	

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ■ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
42 CFR 447.253 and 447.45	a. FFY 2002 $0.00 b. FFY 2003 $0.00
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):
Attachment 4.19-A, Item 1, Page 10e Attachment 4.19-A, Item 1, Page 10j(2)	Same (TN 01-10) Same (TN 01-10)

10. SUBJECT OF AMENDMENT: **The purpose of this amendment is to clarify rules governing DSH payment methodologies regarding final payments and adjustments.**

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT ■ OTHER, AS SPECIFIED: The Governor does not review state plan material

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: David W Hood	16. RETURN TO: State of Louisiana Department of Health and Hospitals 1201 Capitol Access Road PO Box 91030 Baton Rouge, LA 70821-9030
13. TYPED NAME: David W. Hood	
14. TITLE: Secretary	
15. DATE SUBMITTED: September 23, 2002	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 27, 2002	18. DATE APPROVED: November 1, 2002

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: September 7, 2002	20. SIGNATURE OF REGIONAL OFFICIAL: Charlene Brown for Dennis Smith
21. TYPED NAME: Charlene Brown	22. TITLE: Deputy Director, CMSO

23. REMARKS:

FORM HCFA-179 (07-92)

Item I.D.3.a(3) for public state-operated hospitals

Item I.D.3.b(4) for small rural hospitals

Item I.D.3.c(3) for large public non-state hospitals

Item I.D.3.d(6) for all other hospitals

b. Appropriate action shall be taken to recover any overpayments resulting from the use of erroneous data, or if it is determined upon audit that a hospital did not qualify.

c. DSH payments to a hospital determined under any of the methodologies below shall not exceed the hospital's net uncompensated cost as defined in Item I.D.2.f. for the state fiscal year to which the payment is applicable.

d. Qualification is based on the hospital's latest filed cost report. For hospitals with distinct part psychiatric units, qualification is based on the entire hospital's utilization. Hospitals must file cost reports in accordance with Medicare deadlines, including extensions. Hospitals that fail to timely file Medicare cost reports shall be assumed to be ineligible for disproportionate share payments.

Hospitals are notified by letter at least 60 days in advance of calculation of the DSH payment to submit documentation required to establish DSH qualification. Required documents are: 1) obstetrical qualification criteria form; 2) low income utilization revenue calculation; 3) Medicaid cost report; 4) uncompensated cost calculation. Only hospitals which have submitted the qualification documentation by the deadline stated in the notification letter will be considered for disproportionate share payments.

After the final payment during the state fiscal year has been issued, no adjustment will be given on DSH payments for non-state operated hospitals even if subsequently submitted documentation demonstrates an increase in uncompensated care costs for the qualifying hospital.

this pool of hospitals. If the cost reporting period is not a full period (twelve months), actual uncompensated cost data for the previous cost reporting period may be used on a pro rata basis to equate to a full year.

4) A pro rata decrease necessitated by conditions specified in I.D.2.a. above for hospitals described in this section will be calculated based on the ratio determined by dividing the hospitals' uncompensated costs by the uncompensated costs for all qualifying hospitals in this section, then multiplying by the amount of disproportionate share payments calculated in excess of the federal DSH allotment or the state DSH apportioned amount. No additional payments shall be made after the final payment for the state fiscal year is disbursed by the Department. Recoupments shall be initiated upon completion of an audit if it is determined that the actual uncompensated care costs for the state fiscal year for which the payment is applicable is less than the actual amount paid.